

SENATE, No. 20

STATE OF NEW JERSEY 216th LEGISLATURE

INTRODUCED MAY 14, 2015

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Senator LORETTA WEINBERG

District 37 (Bergen)

SYNOPSIS

The “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.”

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 12/11/2015)

1 AN ACT concerning health insurance, health care providers, and
2 health care data and supplementing various parts of the statutory
3 law.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. This act shall be known and may be cited as the “Out-of-
9 network Consumer Protection, Transparency, Cost Containment and
10 Accountability Act.”

11
12 2. The Legislature finds and declares that:

13 a. The health care delivery system in New Jersey needs
14 reforms that will increase transparency in pricing for health care
15 services, enhance consumer protections, create a system to resolve
16 certain health care billing disputes, contain rising costs, and
17 measure success with respect to these goals;

18 b. Despite existing State and federal laws and regulations to
19 protect against certain surprise out-of-network charges, these
20 charges continue to pose a problem for health care consumers in
21 New Jersey. Many consumers find themselves with surprise bills
22 for hospital emergency room procedures or for charges by providers
23 that the consumer had no choice in selecting;

24 c. Notwithstanding that out-of-network benefits are a health
25 insurance benefit enhancement for which insureds pay an additional
26 premium, in recent years, out-of-network coverage has been used as
27 a means to diminish consumer’s health insurance coverage,
28 exposing consumers to additional costs;

29 d. Health insurers and consumers continue to report exorbitant
30 charges by certain health care professionals and facilities for out-of-
31 network services, including balance billing, and in certain cases,
32 consumers’ bills are referred to collections, which contributes to the
33 increasing costs of health care services and insurance and imposes
34 hardships on health care consumers;

35 e. Health care providers and hospitals report that inadequate
36 reimbursement from health insurers and government payers is
37 causing financial stress on safety net hospitals, deteriorating morale
38 amongst providers and reduced quality of care for consumers;

39 f. In order to collect necessary data to better implement
40 reforms to the health care system to address these stated ills, it is
41 necessary to establish a Healthcare Price Index system, or HPI, to
42 collect data that can be used to fill critical information gaps as
43 consumers, public policymakers, health care providers, researchers,
44 quality improvement organizations, and carriers seek solutions for
45 transforming health care delivery;

46 g. An HPI can systematically collect health care data to inform
47 health policy initiatives and to further cost containment and quality
48 improvement efforts;

1 h. An HPI would include medical, pharmacy, and behavioral
2 health claims and be used to report cost, use, and quality
3 information. To mask the identity of patients and ensure privacy,
4 an HPI would be required to comply with the applicable provisions
5 of the federal health privacy rule set forth in sections 160 and 164
6 of Title 45, Code of Federal Regulations, and with other proprietary
7 requirements related to the collection and release of health care
8 data;

9 i. By including all claims information into an HPI, New Jersey
10 can gain a more complete picture of how much health care costs,
11 how much providers receive for the same or similar services, the
12 resources used to treat patients, and variations across the State, and
13 among providers, in the total cost to treat an illness or medical
14 event. In turn, businesses, consumers, providers, and policymakers
15 can use the non-proprietary information to make better-informed
16 decisions about cost-effectiveness and the quality of care;

17 j. An HPI is also an important source of information for
18 designing and implementing an effective arbitration system for
19 emergency and inadvertent out-of-network charges, and other
20 payment and delivery system reforms, such as pay-for-performance,
21 episode-of-care payments, global payments, medical homes,
22 reference based pricing, and accountable care organizations;

23 k. Studies confirm that the United States spends significantly
24 more on health care than other countries but, on the whole, does not
25 produce better results for patients and does not receive equivalent
26 value for each health care dollar spent;

27 l. The Institute of Medicine of the National Academy of
28 Sciences has estimated that up to 30 percent of spending on health
29 care in the United States is wasted; however, without
30 comprehensive data on the costs, components, results, and
31 demographics of care, it is difficult to identify and eliminate waste;
32 and, without reliable information about how and where health care
33 dollars are spent and how patients move through the system, states
34 cannot design effective programs to address both unnecessary and
35 inadequate care; and

36 m. It is, therefore, in the public interest to create the consumer
37 protections provided for in this act and to establish an HPI and
38 increase transparency in health care cost and utilization patterns in
39 New Jersey to provide consumers, policymakers, providers,
40 researchers, quality improvement organizations, and carriers with
41 the information needed to support necessary health care reforms
42 that will lead to a more cost-effective, high-quality health care
43 system that benefits the citizens of this State.

44

45 3. As used in this act:

46 “Carrier” means an entity that contracts or offers to contract to
47 provide, deliver, arrange for, pay for, or reimburse any of the costs
48 of health care services under a health benefits plan, including: an

1 insurance company authorized to issue health benefits plans; a
2 health maintenance organization; a health, hospital, or medical
3 service corporation; a multiple employer welfare arrangement; an
4 entity providing or administering a self-funded health benefits plan;
5 an entity under contract with the State Health Benefits Program and
6 the School Employees' Health Benefits Program to administer a
7 health benefits plan; or any other entity providing a health benefits
8 plan.

9 "Commissioner" means the Commissioner of Banking and
10 Insurance.

11 "Covered person" means a person on whose behalf a carrier is
12 obligated to pay health care expense benefits or provide health care
13 services.

14 "Department" means the Department of Banking and Insurance.

15 "Health benefits plan" means a benefits plan which pays or
16 provides hospital and medical expense benefits for covered
17 services, and is delivered or issued for delivery in this State by or
18 through a carrier. For the purposes of this act, "health benefits
19 plan" shall not include the following plans, policies or contracts:
20 Medicaid, Medicare Advantage, accident only, credit, disability,
21 long-term care, TRICARE supplement coverage, coverage arising
22 out of a workers' compensation or similar law, automobile medical
23 payment insurance, personal injury protection insurance issued
24 pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), and hospital
25 confinement indemnity coverage.

26 "Health care data" means data from a reporting entity relating to
27 the provision, financing, and administration of health care, as
28 applicable. Health care data shall include, but not be limited to,
29 information regarding: medical, pharmacy, and behavioral health
30 claims; health care utilization; health care safety and quality; health
31 outcomes; health care providers; and costs.

32 "Health care facility" means a health care facility licensed
33 pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

34 "Health care professional" means an individual, acting within the
35 scope of his licensure or certification, who provides a covered
36 service defined by the health benefits plan. "Health care
37 professional" includes, but is not limited to, a physician and other
38 health care professionals licensed pursuant to Title 45 of the
39 Revised Statutes.

40 "Health care provider" or "provider" means a health care
41 professional or health care facility.

42 "Inadvertent out-of-network services" means health care services
43 that are: covered under a managed care health benefits plan that
44 provides a network; and provided by an out-of-network health care
45 provider in the event that a covered person utilizes an in-network
46 health care facility for covered health care services and, for any
47 reason, in-network health care services are unavailable in that
48 facility.

1 “Index” or “HPI” means the Healthcare Price Index system
2 established pursuant to this act.

3 “Medicaid” means the State Medicaid program established
4 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

5 “Medicare” means the federal Medicare program established
6 pursuant to Pub.L.89-97 (42 U.S.C. s.1395 et seq.).
7

8 4. a. Prior to scheduling an appointment with a covered person
9 for a non-emergency or elective procedure, and at least 30 days
10 prior to the procedure, or upon scheduling the appointment if the
11 procedure is scheduled to occur in less than 30 days, a health care
12 facility shall provide a written disclosure form to the covered
13 person on which the health care facility shall make the following
14 disclosures, as applicable to each covered person’s health benefits
15 plan, in clear and understandable terms:

16 (1) whether the health care facility is in-network or out-of-
17 network with respect to the covered person’s health benefits plan;

18 (2) if the health care facility is in-network with respect to the
19 person’s health benefits plan, the health care facility shall disclose
20 that:

21 (a) the covered person will have a financial responsibility
22 applicable to an in-network procedure and not in excess of the
23 covered person’s copayment, deductible, or coinsurance as provided
24 in the covered person’s health benefits plan;

25 (b) unless the covered person, at the time of the disclosure
26 required pursuant to this subsection, has knowingly, voluntarily,
27 and specifically selected an out-of-network provider to provide
28 services, the covered person will not incur any out-of-pocket costs
29 in excess of the charges applicable to an in-network procedure; and

30 (c) any bills, charges or attempts to collect by the facility, or
31 any health care professional involved in the procedure in excess of
32 the covered person’s copayment, deductible, or coinsurance as
33 provided in the covered person’s health benefits plan in violation of
34 subparagraph (b) of this paragraph should be reported to the
35 covered person’s carrier and the relevant regulatory entity; and

36 (3) if the health care facility is out-of-network with respect to
37 the covered person’s health benefits plan, the health care facility
38 shall disclose that:

39 (a) certain health care services will be provided on an out-of-
40 network basis, including those health care services associated with
41 the health care facility; and

42 (b) the covered person will have a financial responsibility
43 applicable to health care services provided at an out-of-network
44 facility, in excess of the covered person’s copayment, deductible, or
45 coinsurance, and the covered person may be responsible for any
46 costs in excess of those allowed by their health benefits plan, and
47 that the covered person should contact the covered person’s carrier
48 for further consultation on those costs.

1 b. The facility shall, prior to the procedure, and in terms the
2 covered person typically understands, provide the covered person
3 with a clear and understandable:

- 4 (1) description of the procedure;
5 (2) reasonable estimate of the costs for those services to be
6 charged by that facility;
7 (3) information, if available, on all other costs related to the
8 procedure including costs associated with any health care
9 professionals or other services involved in the procedure and, if
10 unavailable, the fact that the information is unavailable; and
11 (4) notice to the covered person to contact the covered person's
12 carrier for further consultation on the costs of the procedure.

13 c. A health care facility shall, prior to the performance of the
14 procedure, ensure that the covered person signs and returns the
15 disclosure form to the health care facility, either electronically or in
16 paper form.

17 d. If, between the time the notice required pursuant to
18 subsection a. of this section is provided to the covered person and
19 the time the procedure takes place, the network status of the facility
20 changes as it relates to the covered person's health benefits plan, the
21 facility shall notify the covered person promptly.

22 e. The Department of Health shall specify in further detail the
23 content and design of the disclosure form and the manner in which
24 the form shall be provided.

25

26 5. a. Prior to scheduling an appointment with a covered person
27 for a non-emergency or elective procedure, and at least 30 days
28 prior to the procedure, or upon scheduling the appointment if the
29 procedure is scheduled to occur in less than 30 days, a health care
30 professional shall provide a written disclosure form to the covered
31 person on which the health care professional shall make the
32 following disclosures, as applicable to each covered person's health
33 benefits plan, in clear and understandable terms:

34 (1) whether the health care professional is in-network or out-of-
35 network with respect to the covered person's health benefits plan;

36 (2) if the health care professional is in-network with respect to
37 the person's health benefits plan, the health care provider shall
38 disclose that:

39 (a) the covered person will have a financial responsibility
40 applicable to an in-network procedure and not in excess of the
41 covered person's copayment, deductible, or coinsurance as provided
42 in the covered person's health benefits plan;

43 (b) unless the covered person, at the time of the disclosure
44 required pursuant to this subsection, has knowingly, voluntarily,
45 and specifically selected an out-of-network provider to provide
46 services, the covered person will not incur any out-of-pocket costs
47 in excess of the charges applicable to an in-network procedure; and

1 (c) any bills, charges or attempts to collect by the provider, or
2 any health care facility involved in the procedure in excess of the
3 covered person's copayment, deductible, or coinsurance as provided
4 in the covered person's health benefits plan in violation of
5 subparagraph (b) of this paragraph should be reported to the
6 covered person's carrier and the relevant regulatory entity; and

7 (3) if the health care professional is out-of-network with respect
8 to the covered person's health benefits plan, the health care
9 professional shall disclose that:

10 (a) certain health care services will be provided on an out-of-
11 network basis, including those health care services associated with
12 the health care professional; and

13 (b) the covered person will have a financial responsibility
14 applicable to health care services provided by an out-of-network
15 professional, in excess of the covered person's copayment,
16 deductible, or coinsurance, and the covered person may be
17 responsible for any costs in excess of those allowed by their health
18 benefits plan, and that the covered person should contact the
19 covered person's carrier for further consultation on those costs.

20 b. The professional shall, prior to the procedure, and in terms
21 the covered person typically understands, provide the covered
22 person with a clear and understandable:

23 (1) description of the procedure;

24 (2) reasonable estimate of the costs for those services to be
25 charged by that professional;

26 (3) information, if available, on all other costs related to the
27 procedure including costs associated with any health care
28 professionals or other services involved in the procedure and, if
29 unavailable, the fact that the information is unavailable; and

30 (4) notice to the covered person to contact the covered person's
31 carrier for further consultation on the costs of the procedure.

32 c. A health care professional shall, prior to the performance of
33 the procedure, ensure that the covered person signs and returns the
34 disclosure form to the health care professional, either electronically
35 or in paper form.

36 d. If, between the time the notice required pursuant to
37 subsection a. of this section is provided to the covered person and
38 the time the procedure takes place, the network status of the
39 professional changes as it relates to the covered person's health
40 benefits plan, the professional shall notify the covered person
41 promptly.

42 e. The appropriate professional or occupational licensing board
43 within the Division of Consumer Affairs in the Department of Law
44 and Public Safety shall specify in further detail the content and
45 design of the disclosure form and the manner in which the form
46 shall be provided.

47

1 6. a. A carrier shall disclose in writing to a covered person, at
2 the time of enrollment in the plan, on the carrier's website, and
3 upon request thereafter, for each health benefits plan offered in this
4 State:

5 (1) a list of all providers that are in-network with respect to each
6 health benefits plan, which list shall be updated at least every 20
7 days; and

8 (2) such other information as the commissioner determines
9 appropriate and necessary to ensure that a covered person receives
10 sufficient information necessary to make a well-informed health
11 care decision.

12 b. If a carrier authorizes a covered health care service to be
13 performed by an in-network health care provider with respect to any
14 health benefits plan, and the provider or facility status changes to
15 out-of-network before the authorized service is performed, the
16 carrier shall notify the covered person that the provider or facility is
17 no longer in-network as soon as practicable. If the carrier fails to
18 provide the notice at least 30 days prior to the authorized service
19 being performed, the covered person's financial responsibility shall
20 be limited to the financial responsibility the covered person would
21 have incurred had the provider been in-network with respect to the
22 covered person's health benefits plan.

23

24 7. a. If a covered person receives medically necessary services
25 at any health care facility on an emergency or urgent basis, the
26 facility shall not bill the covered person in excess of any deductible,
27 copayment, or coinsurance amount applicable to in-network
28 services pursuant to the covered person's health benefits plan.

29 b. If a covered person receives medically necessary services at
30 an out-of-network health care facility on an emergency or urgent
31 basis, the health care facility shall not bill the carrier in excess of an
32 amount that is the maximum of the payment range established by
33 section 11 of this act. If the carrier and facility cannot agree on a
34 reimbursement rate for these services within 30 days after the
35 carrier is billed for the service, the carrier or health care facility
36 may initiate binding arbitration pursuant to section 13 of this act.

37 c. If a health care facility is in-network with respect to any
38 health benefits plan, the facility shall ensure that all providers
39 providing services in the facility on an emergency or urgent basis
40 accept reimbursement rates in accordance with section 8 of this act.

41 d. A health care facility that contracts with a carrier to be in-
42 network with respect to any health benefits plan shall annually
43 report to the Department of Health:

44 (1) the health benefits plans with which the facility has an
45 agreement to be in-network;

46 (2) the number of health care professionals, by specialty, that
47 provide services in the facility and whether those professionals
48 participate in the same health benefits networks as the facility; and

1 (3) if any health care professionals that provide services in the
2 facility are not in-network with respect to any health benefits plan
3 in which the facility is in-network, confirmation that the facility has
4 an agreement in place for professionals providing services in the
5 facility to otherwise comply with section 8 of this act.

6 e. The Department of Health shall make the information
7 collected pursuant to subsection d. of this section available to the
8 Department of Banking and Insurance.

9
10 8. If a covered person receives:

11 a. inadvertent out-of-network services; or

12 b. medically necessary services at an in-network or out-of-
13 network health care facility on an emergency or urgent basis, the
14 health care professional performing those services shall not bill:

15 (1) the covered person in excess of any deductible, copayment,
16 or coinsurance amount applicable to in-network services pursuant to
17 the covered person's health benefits plan; and

18 (2) the carrier in excess of an amount that is the maximum of
19 the payment range established pursuant to section 11 of this act. If
20 the carrier and the professional cannot agree on a reimbursement
21 rate for these services within 30 days after the carrier is billed for
22 the service, the carrier or professional may initiate binding
23 arbitration pursuant to section 13 of this act.

24
25 9. a. The Commissioner of Banking and Insurance shall select
26 an organization to maintain the Healthcare Price Index, in
27 accordance with the terms of a written agreement which shall be
28 entered into between the department and the organization, as further
29 described in this act. The commissioner shall select an organization
30 that possesses the capabilities to develop and implement policies
31 and procedures for the collection, processing, storage, protection,
32 management and analysis of health care data in accordance with this
33 act. The organization, at the commissioner's direction, shall:

34 (1) collect the health care data from the carriers, which are also
35 referred to herein as the reporting entities;

36 (2) if directed by the commissioner, incorporate other health
37 care data sets such as Medicaid, Medicare or Hospital Discharge
38 Data with the data collected and held by the organization;

39 (3) determine the standards and methods necessary for
40 collecting health care data in a manner that minimizes the cost and
41 administrative burden on carriers and utilizes uniform reporting
42 systems for the collection of data on a scheduled basis;

43 (4) comply with the applicable provisions of the federal health
44 privacy rule set forth in sections 160 and 164 of Title 45, Code of
45 Federal Regulations, and with other proprietary requirements
46 related to the collection and release of health care data;

47 (5) electronically publish on the department's website a list of
48 median paid in-network claims which will be utilized to support the

1 payment range for any amount billed by an out-of-network health
2 care provider and reimbursed by a carrier pursuant to section 11 of
3 this act; and

4 (6) allow access to state entities and not for profit researchers
5 that execute data use agreements with the department, which
6 agreement shall be subject to review and approval by the
7 commissioner, to utilize the non-proprietary portions of the index to
8 measure trends and identify outliers within the State health care
9 system related to: health care safety and quality; health care
10 utilization; health outcomes; costs; efficiency and other areas in the
11 public interest as identified by the commissioner.

12 b. The commissioner may solicit, receive, and accept grants,
13 funds, or anything of value from any public or private entity and
14 receive and accept fees or contributions of money, property, labor,
15 or any other thing of value from any legitimate source to support
16 the operation of the index, provided that: (1) the commissioner does
17 not have reason to believe that the entity may have a vested interest
18 in the decisions of the commissioner or the organization concerning
19 the operation of the index; and (2) any funds received are disclosed
20 on the department's website.

21 c. The purpose of the index shall be to serve as a source for
22 useful, objective, reliable, and comprehensive health information
23 designed to:

24 (1) identify and electronically publish annually the list of
25 median in-network paid commercial claims for the payment range
26 as established in section 11 of this act; and

27 (2) make health care data available to the State and to
28 researchers to improve health care quality, reduce health care costs,
29 and increase pricing transparency.

30 d. Carriers shall file that health care data determined by the
31 commissioner to be necessary to carry out the purposes of this act.
32 The form, medium, content, and frequency of the reporting shall be
33 established by the commissioner but shall be reported not less than
34 annually. Upon request by the commissioner, carriers shall report
35 2014 data to the department to be shared with the organization to
36 effectuate the purposes of this act as soon as practicable upon the
37 effective date of this act.

38 e. Each carrier, as a reporting entity, shall submit a completed
39 health care claims data set for all covered persons who are New
40 Jersey residents in accordance with the requirements of this section.
41 Each carrier shall also be responsible for the submission of health
42 care claims processed by any subcontractor on its behalf. The health
43 care claims data set to be reported shall include, but not be limited
44 to, the following files, as applicable: a medical claims file; a
45 pharmacy claims file; a behavioral health claims file; a provider
46 file; and a covered person eligibility file containing records
47 associated with each of the claims files reported. The completed
48 health care claims data set shall also include, but not be limited to, a

1 record of all claims, including the amount billed for by the provider
2 and the amount paid by the carrier, for which information is
3 submitted to the commissioner by carriers pursuant to sections 5
4 and 6 of P.L.1999, c.155 (C.17B:30-30 and 17B:30-31).

5
6 10. a. The agreement between the department and the
7 organization shall specify the form, medium, content, and frequency
8 of reporting of the health care data, consistent with the provisions
9 of section 9 of this act, to the organization by carriers as determined
10 by the commissioner to be necessary to effectuate the purposes of
11 this act. The agreement shall be considered a contract for
12 professional services pursuant to section 8 of P.L.2005, c.336
13 (C.52:34-10.8) due to the advanced actuarial and health care cost
14 expertise and knowledge required of the organization.

15 b. The agreement between the department and the organization
16 shall require the organization to submit sufficient information about
17 the index and its use to enable the department to produce reports
18 utilizing the data contained within the index, as the commissioner
19 determines to be in furtherance of the purposes of this act.

20 c. The department shall, within 30 days of the date of
21 enactment of this act, select a data storage contractor. The data
22 storage contractor shall: (1) house and ensure the security of the
23 data collected pursuant to this act; and (2) identify the format in
24 which the data should be collected and analyzed to effectuate the
25 purposes of this act. The data storage contractor shall be either: (1)
26 an existing State entity that has the capacity to store and secure the
27 data; or (2) selected pursuant to an existing State contract for data
28 warehousing.

29
30 11. The agreement between the department and the organization
31 shall require the organization, upon review and analysis of the
32 health care data submitted for the purposes of the Healthcare Price
33 Index, to establish a list of median in-network commercial paid
34 claims for health care services in New Jersey. The organization
35 shall update the list annually and the department shall publish it on
36 its website. Using the list, the organization shall establish a
37 reasonable and clearly defined payment range for any amount billed
38 by an out-of-network health care provider and reimbursed by a
39 carrier for out-of-network services provided on an emergency or
40 urgent basis and as inadvertent out-of-network services. The
41 payment range shall indicate a minimum and maximum allowable
42 payment for any applicable service, which minimum shall be 75%
43 and maximum shall be 250%, of the median paid in-network
44 commercial claim for a service, as identified by the list of in-
45 network commercial paid claims created pursuant to this section.

46
47 12. Notwithstanding any law, rule, or regulation to the contrary:

1 a. With respect to a carrier, if a covered person receives
2 inadvertent out-of-network services, or services at an in-network or
3 out-of-network health care facility on an emergency or urgent basis,
4 the carrier shall ensure that the covered person incurs no greater
5 out-of-pocket costs than the covered person would have incurred
6 with an in-network health care provider for covered services.
7 Pursuant to section 8 of this act, the out-of-network provider shall
8 not bill the covered person, except for applicable deductible,
9 copayment, or coinsurance amounts that would apply if the covered
10 person utilized an in-network health care provider for the covered
11 services.

12 b. A covered person may agree in writing to assign benefits
13 that the covered person receives for health care services provided
14 pursuant to subsection a. of this section to the out-of-network health
15 care provider. If the benefits are assigned:

16 (1) any reimbursement paid by the carrier shall be paid directly
17 to the out-of-network provider; and

18 (2) the carrier shall provide the out-of-network provider with a
19 written explanation of benefits that specifies the proposed
20 reimbursement and the applicable deductible, copayment, or
21 coinsurance amounts owed by the covered person.

22 c. If inadvertent out-of-network services or services provided
23 at an in-network or out-of-network health care facility on an
24 emergency or urgent basis are performed in accordance with
25 subsection a. of this section, the out-of-network provider may bill
26 the carrier for the services rendered, in an amount that is within the
27 payment range established by section 11 of this act. The carrier
28 may pay the billed amount or attempt to negotiate reimbursement
29 with the out-of-network health care provider.

30
31 13. a. If attempts to negotiate reimbursement for services
32 provided by an out-of-network health care provider, pursuant to
33 subsection c. of section 12 of this act, do not result in a resolution
34 of the payment dispute within 30 days after the carrier is billed for
35 the services by the out-of-network health care provider, the carrier
36 or out-of-network health care provider may initiate binding
37 arbitration to determine payment for the services.

38 b. The binding arbitration shall adhere to the following
39 requirements:

40 (1) The party requesting arbitration shall notify the other party
41 that arbitration has been initiated and state its final offer before
42 arbitration. In response to this notice, the nonrequesting party shall
43 inform the requesting party of its final offer before the arbitration
44 occurs. Both final offers shall be within the payment range for the
45 applicable service, as established by the organization, based on the
46 organization's review of the Healthcare Price Index pursuant to the
47 provisions of section 11 of this act;

1 (2) Arbitration shall be initiated by filing a request with the
2 department;

3 (3) The department shall contract with one or more entities that
4 have experience in health care pricing. The department may utilize
5 the entity engaged under the “Health Claims Authorization,
6 Processing, and Payment Act,” P.L.2005, c.352 (C.17B:30-48 et
7 seq.), for arbitration under this act. Claims that are subject to
8 arbitration pursuant to the provisions of this act, which previously
9 would be subject to arbitration pursuant to the “Health Claims
10 Authorization, Processing, and Payment Act,” shall instead be
11 subject to this act;

12 (4) The arbitration shall consist of a review of the written
13 submissions by both parties, which shall include the final offer for
14 the payment by the carrier for the out-of-network health care
15 provider’s fee, and the final offer by the out-of network provider for
16 the fee the provider will accept as payment from the carrier; and

17 (5) The arbitrator’s decision shall be one of the two amounts
18 submitted by the parties as their final offers and shall be binding on
19 both parties. The decision of the arbitrator shall include written
20 findings and shall be issued within 30 days after the request is filed
21 with the department. The arbitrator’s expenses and fees shall be
22 paid as provided in the decision. Each party shall be responsible for
23 its own costs and fees, including legal fees if any.

24 c. In making a determination pursuant to subsection b. of this
25 section, the arbitrator shall consider:

26 (1) the level of training, education, and experience of the health
27 care professional;

28 (2) the health care provider’s usual charge for comparable
29 services provided out-of-network with respect to any health benefits
30 plans;

31 (3) the circumstances and complexity of the particular case,
32 including the time and place of the service;

33 (4) individual patient characteristics; and

34 (5) the usual and customary cost of the service in the county,
35 including the list of median commercial paid in-network claims for
36 the service as established by the Healthcare Price Index pursuant to
37 section 11 of this act.

38 d. The interest charges for overdue payments, pursuant to
39 P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the
40 pendency of a decision under subsection b. of this section and any
41 interest required to be paid a provider under P.L.1999,
42 c.154 (C.17B:30-23 et al.) shall not accrue until after 30 days
43 following an arbitrator’s decision as provided in subsection b. of
44 this section, but in no circumstances longer than 150 days from the
45 date that the out-of-network provider billed the carrier for services
46 rendered.

47 e. This section shall apply only if the covered person complies
48 with any applicable preauthorization or review requirements of the

1 health benefits plan regarding the determination of medical
2 necessity to access in-network inpatient or outpatient benefits.

3 f. This section shall not apply to a covered person who
4 knowingly, voluntarily, and specifically chooses an out-of-network
5 provider for health care services.

6
7 14. On or before January 31 of each calendar year, the
8 commissioner shall consult with the Department of the Treasury,
9 the relevant professional and occupational licensing boards within
10 the Division of Consumer Affairs in the Department of Law and
11 Public Safety, and the Department of Health, to obtain information
12 to compile and make publicly available, on the department's
13 website:

14 a. A list of all arbitrations filed pursuant to section 13 of this
15 act between January 1 and December 31 of the previous calendar
16 year, including the percentage of all claims that were arbitrated.

17 (1) For each arbitration decision, the list shall include but not be
18 limited to:

19 (a) an indication of whether the decision was in favor of the
20 carrier or the out-of-network health care provider;

21 (b) the arbitration bids offered by each side and the award
22 amount;

23 (c) the category and practice specialty of each out-of-network
24 health care provider involved in an arbitration decision, as
25 applicable; and

26 (d) a description of the service that was provided and billed for.

27 (2) The list of arbitration decisions shall not include any
28 information specifically identifying the provider, carrier, or covered
29 person involved in each arbitration decision.

30 b. The percentage of facilities and hospital-based professionals,
31 by specialty, that are in-network for each carrier in this State as
32 reported pursuant to subsection d. of section 7 of this act.

33 c. The list of the 50 most common median paid in-network
34 Current Procedural Terminology (CPT) codes as established by the
35 HPI pursuant to section 11 of this act.

36 d. The number of complaints the department receives relating
37 to out-of-network health care services.

38 e. The number of and description of claims received by the
39 State Health Benefits Program and the School Employees' Health
40 Benefits Program for in-State emergency out-of-network health care
41 and inadvertent out-of-network health care.

42 f. Annual trends on health benefits plan premium rates, total
43 annual amount of spending on inadvertent and emergency out-of-
44 network costs by health benefits plans, and medical loss ratios in
45 the State to the extent that the information is available.

46 g. The number of physician specialists practicing in the State in
47 a particular specialty and whether they are in or out-of-network
48 with respect to the carriers that administer the State Health Benefits

1 Program, the School Employees' Health Benefits Program, the
2 qualified health plans in the federally run health exchange in the
3 State, and other health benefits plans offered in the State.

4 h. Any other benchmarks or information obtained pursuant to
5 this act that the commissioner deems appropriate to make publicly
6 available to further the goals of the act.

7
8 15. a. There is established in the Department of the Treasury a
9 nonlapsing revolving fund to be known as the "Healthcare Price
10 Index Trust Fund." This fund shall be the repository for monies
11 collected pursuant to subsection c. of this section and other monies
12 received as grants or otherwise appropriated for the purposes of the
13 index. The monies in the fund shall be used only to pay for
14 administrative and operational expenses that the department incurs
15 in order to carry out its responsibilities pursuant to this act,
16 including funding the organization pursuant to the agreement
17 between the department and the organization, and shall be
18 specifically dedicated and utilized exclusively for this purpose.

19 b. The State Treasurer shall be the custodian of the fund, and
20 all disbursements from the fund shall be made by the State
21 Treasurer upon vouchers signed by the commissioner or the
22 commissioner's designee. The monies in the fund shall be invested
23 and reinvested by the Director of the Division of Investment in the
24 Department of the Treasury as are other trust funds in the custody
25 of the State Treasurer in the manner provided by law. Interest
26 received on the monies in the fund shall be credited to the fund.

27 c. (1) The commissioner shall apply, and periodically revise as
28 necessary, an annual surcharge to all health benefits plans, or to any
29 third party administrators administering a health benefit plan, in the
30 State, on a pro rata basis according to the number of covered
31 persons in each health benefits plan, as the commissioner
32 determines necessary to effectuate the purposes of this act.

33 (2) Any surcharges or assessments applied by the commissioner
34 pursuant to paragraph (1) of this subsection shall not be fixed at a
35 level that would generate revenue in excess of amounts necessary to
36 effectuate the purposes of this act.

37 (3) The department and organization may charge a reasonable
38 user fee to state entities and not for profit researchers for the right
39 to access and use the data contained within the index; however, the
40 fee may be reduced or waived for users that demonstrate a plan to
41 use the data in research of general value to the public health or an
42 inability to pay the scheduled fee, as provided in rules to be adopted
43 by the commissioner.

44 (4) The department or organization may provide technical
45 assistance to other public or private entities, for a fee, utilizing data
46 released for the purposes of the index.

47 (5) The proceeds collected pursuant to this subsection shall be
48 deposited into the fund.

1 (6) Information concerning monies collected pursuant to this
2 subsection, including other monies received as grants or otherwise
3 appropriated for the purposes of the index, and any fees collected
4 for the right to access and use the data contained within the index,
5 shall be disclosed and made available on the department website.
6 The information shall be updated at least every 60 days.

7 d. The penalties collected pursuant to section 19 of this act
8 shall be deposited into the fund.

9
10 16. a. Within 90 days of the effective date of this act, a carrier
11 shall provide a written notice, in a form and manner to be
12 prescribed by the Commissioner of Banking and Insurance, to each
13 covered person of the protections provided to covered persons
14 pursuant to this act. The notice shall include information on how a
15 consumer can contact the department or the appropriate regulatory
16 agency to report and dispute an out-of-network charge. The notice
17 required pursuant to this section shall be posted on the carrier's
18 website.

19 b. The commissioner shall provide a notice on the department's
20 website containing information for consumers relating to the
21 protections provided by this act and information on how consumers
22 can report and file complaints with the department or the
23 appropriate regulatory agency relating to any out-of-network
24 charges.

25
26 17. a. The commissioner shall annually calculate the savings to
27 each carrier that result from a reduction in out-of-network claims
28 payments pursuant to the provisions of this act.

29 b. With respect to a carrier that is subject to a minimum loss
30 ratio requirement, any savings to the carrier calculated pursuant to
31 subsection a. of this section that result from the provisions of this
32 act, shall be factored into any change in premiums collected for any
33 policy form or benefit rider for the purpose of calculating the
34 minimum loss ratio. In each case in which the loss ratio fails to
35 substantially comply with the loss ratio requirement, including any
36 noncompliance resulting from the savings to the carrier resulting
37 from the provisions of this act, the carrier shall issue a dividend or
38 credit against future premiums pursuant to the minimum loss ratio
39 requirement.

40
41 18. a. It shall be a violation of this act if a health care provider,
42 directly or indirectly related to a claim, knowingly waives, rebates,
43 gives, pays, or offers to waive, rebate, give or pay all or part of the
44 deductible, copayment, or coinsurance owed by a covered person
45 pursuant to the terms of the covered person's health benefits plan as
46 an inducement for the covered person to seek health care services
47 from that provider. As the commissioner shall prescribe by
48 regulation, a pattern of waiving, rebating, giving or paying all or

1 part of the deductible, copayment or coinsurance by a provider shall
2 be considered an inducement for the purposes of this subsection.

3 b. This section shall not apply to any waiver, rebate, gift,
4 payment, or offer that falls within a safe harbor under federal laws
5 related to fraud and abuse concerning patient cost-sharing,
6 including, but not limited to, anti-kickback, self-referral, false
7 claims, and civil monetary penalties.

8

9 19. a. A person or entity that violates any provision of this act,
10 or the rules and regulations adopted pursuant hereto, shall be liable
11 to a penalty as provided in this subsection. The penalty shall be
12 collected by the commissioner in the name of the State in a
13 summary proceeding in accordance with the "Penalty Enforcement
14 Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

15 (1) A health care facility or carrier that violates any provision of
16 this act shall be liable to a penalty of not more than \$1,000 for each
17 violation. Every day upon which a violation occurs shall be
18 considered a separate violation, but no facility or carrier shall be
19 liable to a penalty greater than \$25,000 for each occurrence.

20 (2) In addition to any other existing penalties for such acts, a
21 person or entity that receives data under the terms and conditions of
22 this act and intentionally or knowingly uses, sells, or transfers the
23 data for commercial advantage, pecuniary gain, personal gain, or
24 malicious harm, in violation of rules which the commissioner shall
25 adopt, shall be liable to a penalty of not more than \$500,000 for
26 each violation.

27 (3) A person or entity not covered by paragraphs (1) or (2) of
28 this subsection that violates the requirements of this act shall be
29 liable to a penalty of not more than \$100 for each violation. Every
30 day upon which a violation occurs shall be considered a separate
31 violation, but no person or entity shall be liable to a penalty greater
32 than \$2,500 for each occurrence.

33 b. Upon a finding that a person or entity has failed to comply
34 with the requirements of this act, including the payment of a penalty
35 as determined under subsection a. of this section, the commissioner
36 may:

37 (1) in the case of a carrier, initiate such action as the
38 commissioner determines appropriate;

39 (2) in the case of a health care facility, refer the matter to the
40 Commissioner of Health for such action as the Commissioner of
41 Health determines appropriate; or

42 (3) in the case of a health care professional, refer the matter to
43 the appropriate professional or occupational licensing board within
44 the Division of Consumer Affairs in the Department of Law and
45 Public Safety for such action as that board determines appropriate.

46

47 20. The Commissioner of Banking and Insurance, the
48 Commissioner of Health and any relevant licensing board in the

1 Division of Consumer Affairs in the Department of Law and Public
2 Safety under Title 45 of the Revised Statutes may, as appropriate,
3 adopt rules and regulations, pursuant to the "Administrative
4 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), in order to
5 effectuate the purposes of this act.

6
7 21. Sections 9 through 11 and section 14 of this act shall take
8 effect immediately and the remainder of this act shall take effect on
9 the first day of the seventh month next following the date of
10 enactment. The Commissioner of Banking and Insurance, the
11 Department of Health and any relevant licensing board may take
12 such anticipatory administrative action in advance thereof as shall
13 be necessary for the implementation of this act.

14
15
16 **STATEMENT**

17
18 This bill is entitled the "Out-of-network Consumer Protection,
19 Transparency, Cost Containment and Accountability Act." The bill
20 reforms various aspects of the health care delivery system in New
21 Jersey to increase transparency in pricing for health care services,
22 enhance consumer protections, create an arbitration system to
23 resolve certain health care billing disputes, contain rising costs
24 associated with out-of-network health care services, and measure
25 success with regard to these goals.

26
27 **DISCLOSURE**

28
29 The bill places certain responsibilities on health care facilities
30 and health care professionals to notify patients about services that
31 they will provide. The bill uses the term "health care provider" to
32 include both facilities and professionals.

33 Specifically, prior to scheduling an appointment with a covered
34 person and at least 30 days prior to the procedure, a health care
35 facility or health care professional must provide a written disclosure
36 form to the covered person to inform the covered person if the
37 provider is in-network or out-of-network with respect to the covered
38 person's health benefits plan and provide certain other information
39 to help the consumer understand the costs associated with the
40 procedure.

41 Providers, which are defined in the bill to include both facilities
42 and professionals, are required to provide the covered person with a
43 clear and understandable:

- 44 (1) description of the procedure;
45 (2) reasonable estimate of the costs for those services to be
46 charged by that facility;
47 (3) information, if available, on all other costs related to the
48 procedure including costs associated with any health care

1 professionals or other services involved in the procedure and, if
2 unavailable, the fact that the information is unavailable; and

3 (4) notice to the covered person to contact the covered person's
4 health insurance carrier for further consultation on the costs of the
5 procedure.

6 The health care facility or professional must also, prior to the
7 performance of the procedure, ensure that the covered person signs
8 and returns the disclosure form, either electronically or in paper
9 form.

10 The bill also places a variety of responsibilities on health
11 insurance carriers. Carriers include insurance companies authorized
12 to issue health benefits plans; health maintenance organizations;
13 health, hospital, or medical service corporations; multiple employer
14 welfare arrangements; entities providing or administering self-
15 funded health benefits plans; entities under contract with the State
16 Health Benefits Program and the School Employees' Health
17 Benefits Program to administer a health benefits plan; and any other
18 entity providing a health benefits plan.

19 Specifically, a carrier must disclose in writing to a covered
20 person, at the time of enrollment in the plan, on the carrier's
21 website, and upon request thereafter, for each health benefits plan
22 offered in this State:

23 (1) a list of all providers that are in-network with respect to each
24 health benefits plan that is updated at least every 20 days; and

25 (2) such other information as the Commissioner of Banking and
26 Insurance determines appropriate and necessary to ensure that a
27 covered person receives sufficient information necessary to make a
28 well-informed health care decision.

29 The bill also addresses situations in which a carrier authorizes a
30 covered health care service to be performed by an in-network health
31 care provider with respect to any health benefits plan, and the
32 provider or facility status changes to out-of-network before the
33 authorized service is performed. The bill requires the carrier to
34 notify the covered person that the provider or facility is no longer
35 in-network as soon as practicable. If the carrier fails to provide the
36 notice at least 30 days prior to the authorized service being
37 performed, the covered person's financial responsibility shall be
38 limited to the financial responsibility the covered person would
39 have incurred had the provider been in-network with respect to the
40 covered person's health benefits plan.

41

42

OUT-OF-NETWORK BILLING

43

44 The bill also places certain limitations on charges by out-of-
45 network providers in two situations: (1) if a covered person receives
46 medically necessary services at any health care facility on an
47 emergency or urgent basis; and (2) inadvertent out-of-network
48 services. The bill defines "inadvertent out-of-network services" to

1 mean health care services that are: covered under a managed care
2 health benefits plan that provides a network; and provided by an
3 out-of-network health care provider in the event that a covered
4 person utilizes an in-network health care facility for covered health
5 care services and, due to any reason, in-network health care services
6 are unavailable in that facility.

7 The bill protects a covered person receiving medically necessary
8 services at any health care facility on an emergency or urgent basis
9 by prohibiting the provider from billing the covered person in
10 excess of any deductible, copayment, or coinsurance amount
11 applicable to in-network services pursuant to the covered person's
12 health benefits plan.

13 With regard to the medically necessary services at an out-of-
14 network health care facility on an emergency or urgent basis, the
15 health care facility shall not bill the covered person's carrier in
16 excess of an amount that is the maximum of a payment range
17 established in the bill. If the carrier and facility cannot agree on a
18 reimbursement rate for these services within 30 days after the
19 carrier is billed for the service, the carrier or health care facility
20 may initiate binding arbitration.

21 The bill also requires health care facilities that are in-network
22 with respect to any health benefits plan to ensure that all providers
23 providing services in the facility on an emergency or urgent basis
24 accept reimbursement rates in accordance with the bill's provisions
25 and to report certain information to the Department of Health.

26 The bill also provides that if a covered person receives:

- 27 a. inadvertent out-of-network services; or
28 b. medically necessary services at an in-network or out-of-
29 network health care facility on an emergency or urgent basis, the
30 health care professional performing those services shall not bill:

31 (1) the covered person in excess of any deductible, copayment,
32 or coinsurance amount applicable to in-network services pursuant to
33 the covered person's health benefits plan; and

34 (2) the carrier in excess of an amount that is the maximum of
35 the payment range established in the bill. If the carrier and the
36 professional cannot agree on a reimbursement rate for these services
37 within 30 days after the carrier is billed for the service, the carrier
38 or professional may initiate binding arbitration.

39

40 HEALTHCARE PRICE INDEX

41

42 The bill establishes a Healthcare Price Index (HPI). The bill
43 provides that the Commissioner of Banking and Insurance shall
44 select an organization to maintain the HPI, in accordance with the
45 terms of a written agreement which shall be entered into between
46 the department and the organization. The commissioner is required
47 to select an organization that possesses the capabilities to develop
48 and implement policies and procedures for the collection,

1 processing, storage, and analysis of health care data in accordance
2 with the provisions of the bill.

3 The purpose of the HPI is to serve as a useful, objective, reliable,
4 and comprehensive health information index that is designed to:

5 (1) identify and electronically publish annually the list of
6 median in-network paid commercial claims for the payment range
7 as established in the bill; and

8 (2) make health care data available to the State and to not for
9 profit researchers to improve health care quality, reduce health care
10 costs, and increase pricing transparency.

11 Carriers shall file such health care data determined by the
12 commissioner to be necessary to carry out the purposes of the bill.
13 The form, medium, content, and frequency of the reporting shall be
14 established by the commissioner but shall be reported at least
15 annually.

16 The agreement between the department and the organization
17 shall specify the form, medium, content, and frequency of reporting
18 of the health care data, consistent with the bill, to the organization
19 and reporting entities, as determined by the commissioner to be
20 necessary to effectuate the bill's purposes.

21

22 ARBITRATION

23

24 For certain emergency and out-of-network billing situations
25 between providers and carriers, the bill establishes an arbitration
26 system with a payment range to be established by the HPI. The
27 agreement between the department and the organization shall
28 require the organization, upon review of the health care data
29 submitted for the purposes of the HPI, to establish a list of median
30 commercial paid in-network claims for health care services in New
31 Jersey. Using the list, the organization must establish a reasonable
32 and clearly defined payment range for any amount billed by an out-
33 of-network health care provider and reimbursed by a carrier for out-
34 of-network services provided on an emergency or urgent basis and
35 as inadvertent out-of-network services. The payment range shall be
36 between 75% and 250% of the median in-network paid commercial
37 claim for a service, as identified by the list of in-network
38 commercial paid claims created by the HPI.

39 In the event that a covered person receives inadvertent out-of-
40 network services or services at an in-network or out-of-network
41 health care facility on an emergency or urgent basis, the carrier
42 shall ensure that the covered person incurs no greater out-of-pocket
43 costs than the covered person would have incurred with an in-
44 network health care provider for covered services. The out-of-
45 network provider is prohibited from billing the covered person,
46 except for applicable deductible, copayment, or coinsurance
47 amounts that would apply if the covered person utilized an in-
48 network health care provider for the covered services. In these

1 situations, a covered person may agree in writing to assign benefits
2 that the covered person receives for health care services to the out-
3 of-network health care provider. In the event that the benefits are
4 assigned:

5 (1) any reimbursement paid by the carrier shall be paid directly
6 to the out-of-network provider; and

7 (2) the carrier shall provide the out-of-network provider with a
8 written explanation of benefits that specifies the proposed
9 reimbursement and the applicable deductible, copayment, or
10 coinsurance amounts owed by the covered person.

11 If inadvertent out-of-network services or medically necessary
12 services at an in-network or out-of-network health care facility on
13 an emergency or urgent basis are performed, the out-of-network
14 provider may bill the carrier for the services rendered, in an amount
15 that is within the payment range established by the HPI. The carrier
16 may pay the billed amount or attempt to negotiate reimbursement
17 with the out-of-network health care provider.

18 The bill establishes an arbitration system that utilizes the
19 payment range established by the HPI. If attempts to negotiate
20 reimbursement for services provided by an out-of-network health
21 care provider do not result in a resolution of the payment dispute
22 within 30 days after the carrier is billed for the services by the out-
23 of-network health care provider, the carrier or out-of-network health
24 care provider may initiate binding arbitration to determine payment
25 for the services.

26 The binding arbitration system established under the bill
27 provides that the party requesting arbitration shall notify the other
28 party that arbitration has been initiated and state its final offer
29 before arbitration. In response to this notice, the nonrequesting
30 party shall inform the requesting party of its final offer before the
31 arbitration occurs. Both final offers shall be within the payment
32 range for the applicable service, as established by the organization,
33 based on the organization's review of the HPI.

34 Arbitration shall be initiated by filing a request with the
35 department. The arbitrators selected by the department shall be one
36 or more entities that have experience in health care pricing.

37 The arbitrator's decision shall be one of the two amounts
38 submitted by the parties as their final offers and shall be binding on
39 both parties.

40 In making a determination, the arbitrator is to consider:

41 (1) in the case of a health care professional, the level of training,
42 education, and experience of the health care professional;

43 (2) the health care provider's usual charge for comparable
44 services provided out-of-network with respect to any health benefits
45 plans;

46 (3) the circumstances and complexity of the particular case,
47 including the time and place of the service;

48 (4) individual patient characteristics; and

1 (5) the usual and customary cost of the service, including the
2 median commercial paid claim for that service as determined by the
3 index.

4 The arbitration section is not available to a covered person who
5 willfully chooses to access an out-of-network health care provider
6 for health care services.

7 The bill also provides that on or before January 31 of each
8 calendar year, the commissioner shall consult with the Board of
9 Medical Examiners and the Department of Health to obtain
10 information to compile and make publicly available certain
11 information, on the department's website, including a list of all
12 arbitrations filed, and an indication of whether the decision was in
13 favor of the carrier or the out-of-network health care provider.

14 The bill also establishes in the Department of the Treasury a
15 nonlapsing revolving fund to be known as the "Healthcare Price
16 Index Trust Fund." This fund shall be the repository for monies
17 collected pursuant to the bill's provisions and other monies received
18 as grants or otherwise appropriated for the purposes of the index.
19 The monies in the fund shall be used only to pay for administrative
20 and operational expenses that the department incurs in order to
21 carry out its responsibilities pursuant to this bill, including funding
22 the organization pursuant to the agreement between the department
23 and the organization, and shall be specifically dedicated and utilized
24 exclusively for this purpose.

25 The commissioner is charged with applying, and periodically
26 revising as necessary, an annual surcharge to all health benefits
27 plans, or to any third party administrators administering a health
28 benefit plan, in the State, on a pro rata basis according to the
29 number of covered persons in each health benefits plan, as the
30 commissioner determines necessary to effectuate the purposes of
31 the bill. These surcharges or assessments applied by the
32 commissioner shall not be fixed at a level that would generate
33 revenue in excess of amounts necessary to effectuate the purposes
34 of the bill.

35 The department and organization may also charge a reasonable
36 user fee for the right to access and use the data contained within the
37 index; however, the fee may be reduced or waived for users that
38 demonstrate a plan to use the data in research of general value to
39 the public health or an inability to pay the scheduled fee, as
40 provided in rules to be adopted by the commissioner. The
41 department and organization are also permitted to provide technical
42 assistance to other public or private entities, for a fee, utilizing data
43 released for the purposes of the index.

44 Information concerning monies collected pursuant to the bill,
45 including monies received as grants or otherwise appropriated for
46 the purposes of the index, and any fees collected for the right to
47 access and use the data contained within the index, shall be

1 disclosed and made available on the department website. The
2 information shall be updated at least every 60 days.

3 The bill provides that within 90 days of its effective date, a
4 carrier shall provide a written notice to each covered person of the
5 protections provided to covered persons pursuant to the bill. The
6 notice shall include information on how a consumer can contact the
7 department or the appropriate regulatory agency to report and
8 dispute an out-of-network charge. The notice shall be posted on the
9 carrier's website.

10 The bill provides that the commissioner shall annually calculate
11 the savings to each carrier that results from a reduction in out-of-
12 network claims payments pursuant to the provisions of the bill and
13 ensure that any savings to the carrier that results from the
14 provisions of the bill shall be factored into any change in premiums
15 collected for any policy form or benefit rider for the purpose of
16 calculating the minimum loss ratio. In each case in which the loss
17 ratio fails to substantially comply with the loss ratio requirement,
18 including any noncompliance resulting from the savings to the
19 carrier resulting from the provisions of the bill, the carrier shall
20 issue a dividend or credit against future premiums pursuant to the
21 minimum loss ratio requirement.

22

23

WAIVER OF CO-PAYS

24

25 The bill also provides that it is a violation of the bill's provisions
26 if a health care provider, directly or indirectly related to a claim,
27 knowingly waives, rebates, gives, pays, or offers to waive, rebate,
28 give or pay all or part of the deductible, copayment, or coinsurance
29 owed by a covered person pursuant to the terms of the covered
30 person's health benefits plan as an inducement for the covered
31 person to seek health care services from that provider. The bill
32 specifies that a pattern of waiving, rebating, giving or paying all or
33 part of the deductible, copayment or coinsurance by a provider shall
34 be considered an inducement. The bill provides that this section
35 does not apply to any waiver, rebate, gift, payment, or offer that
36 falls within a safe harbor under federal laws related to fraud and
37 abuse concerning patient cost-sharing, including, but not limited to,
38 anti-kickback, self-referral, false claims, and civil monetary
39 penalties. One such safe harbor is for a financial hardship.

40

41

PENALTIES

42

43 A person or entity that violates any provision of the bill, or the
44 rules and regulations adopted pursuant thereto, is liable to a penalty
45 as provided in the bill. Further, upon a finding that a person or
46 entity has failed to comply with the requirements of the bill,
47 including the payment of a penalty, the commissioner may:

S20 VITALE, WEINBERG

25

- 1 (1) in the case of a carrier, initiate such action as the
2 commissioner determines appropriate;
- 3 (2) in the case of a health care facility, refer the matter to the
4 Commissioner of Health for such action as the Commissioner of
5 Health determines appropriate; or
- 6 (3) in the case of a health care professional, refer the matter to
7 the appropriate professional and occupational licensing board
8 within the Division of Consumer Affairs in the Department of Law
9 and Public Safety for such action as that board determines
10 appropriate.